force.

(c) The inflation allowance for direct care staff includes the full amounts granted in Section III.B.1.

(d) The reasonable rate year wage shall be the level of increase required to attract sufficient staff to ensure minimum availability of care as determined by the Department of Public Health for current patients. The wage rate will be determined by the Commission with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

(i) Outlier wage rates as defined by the Division shall be excluded from the computation;

(ii) Special weight shall be given to rates prevailing at non-acute hospitals located in the hospital's Medicare labor market region;

(iii) If it can be demonstrated that direct care staff at a hospital are transferring in significant numbers to another competing hospital, then the wage rates prevailing at that competing hospital shall be given special weight; and

(iv) In no case shall the reasonable rate year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare

labor market region at the time of application.

(v) The determined Medicare Labor Market Regions and their associated counties are as follows:

Medicare Labor Market Region	Counties
Eastern Mass	Bristol
	Essex
	Middlesex
	Norfolk
	Plymouth
	Suffolk
	Worcester
Berkshire	Berkshire
Springfield	Hampden
	Hampshire
Barnstable	Barnestable
	Dukes
	Nantucket
Rural	Franklin

(e) In order to be eligible for this exception,a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the criteria established in St. 1988, Chapter 270. These criteria are:

(i) existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to Department of Public Health standards, Joint Commission on Accreditation of Health Care Organizations standards or other

qualifying guidelines utilized in Massachusetts to ensure adequate care;

(ii) persistent difficulty in recruitment given bona fide recruitment efforts to obtain staffing levels; and

(iii) existing dependency upon temporary nursing services in order to maintain staffing levels.

(8) A CBC is allowable for an increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population. The hospital shall have the burden of demonstrating a net increase in intensity from either the base year or the last year for which a casemix adjustment has been made (whichever was later) to the intermediate or rate year. The higher intensity level in the intermediate or rate year shall be used to adjust RFR.

(a) Psychiatric Hospitals may demonstrate that increases in certain intensity factors between the base year and the intermediate year have led to increases in service intensity e.g., FTEs, nursing hours per patient), which in turn have led to quantifiable increases in cost. Intensity factors include, changes in: age mix, average length of stay, number of involuntary lockup patients, patient disability index, and percentage of patients admitted from an acute hospital. Note that increases in inputs alone are not enough to qualify for an intensity CBC; some intensity-related change in patient characteristics must also be identified.

(b) If the documentation for the increase in intensity is found to be acceptable then the hospital shall have the burden of documenting the increase in patient care costs resulting from the higher level of intensity.

(9) Costs for increases in physician malpractice insurance premiums paid by the hospital for physicians who are employees of the hospital and who do not bill patients or third-party reimbursers separately for their professional services. The amount of the approved exception allowance will be the net of all the increases already determined through the inflation allowance for malpractice insurance premiums from the base year forward and included in the hospital's Medicaid rates. The hospital must document the actual malpractice insurance premium expense, as well as show that the physicians covered are employees of the hospital and do not bill separately for their services. The hospital may include in the CBC request the amount of any retroactive premium payments to be made during the rate year.

No costs other than those meeting the criteria set forth in one or more of the above categories shall constitute a cost beyond the reasonable control of the hospital.

4. New Services

(a) The Commission recognize as a new service any health services that were not offered by a hospital prior to the intermediate year. In order to be recognized as a new service by the Commission, the service to be provided should conform with

the cost reporting requirements contained in 114.1 CMR 40.03. The Commission shall not approve any cost allowances for a new service that is not scheduled to start within six (6) months.

(b) For a new service to be implemented after the start of the hospital's rate year, the allowable cost shall be equal to the reasonable operating costs attributed to the new service cost centers. For a new service started in the base year, the allowable cost shall be equal to the reasonable base year cost attributed to the new service inflated by a base to rate year inflation factor plus a base to rate year allowance for volume adjustment attributed to the new service. according to this state plan.

5. Capital.

The base year capital requirement shall be adjusted to include reasonable projected acquisitions and retirements of fixed equipment and plant, and reasonable projected increases and decreases in amortization, leases and rentals, subject to the limitations contained in 114.1 CMR 40.07(3).

III.C. Determination of Reasonable Financial Requirements (RFR) for the Rate Year

The rate-year RFR is calculated with the following formula:

RFR =

(Rate-Year Operating Requirement +Rate-Year Capital Requirement + Rate-Year Working Capital Requirement) - (Labor Cost Recovery)

1. The rate year operating requirement is the sum of the base-year allowed operating cost and the adjustment of the base-year allowed operating costs to the rate year.

2. The rate year capital requirement is the sum of the base-year allowed capital and the adjustment of the base year capital to the rate year.

3. The rate-year working-capital requirement will be determined by multiplying the sum of the rate-year operating and capital requirements by 0.0055.

III.D. Determination of Approved Gross Patient Service Revenue for the Rate Year

GPSR is determined through one of two methods:

1. Determination of GPSR for Hospitals with Proper Data on Base-Year Charges

   For those hospitals with data on base-year charges, GPSR is calculated as follows:

   a. The RFR of the hospital for the rate year is determined (as described in Section III.D).

   b. From the hospital's RFR subtract the projected amount of non-charge pay reimbursement that the hospital will receive in the rate year. The result of this subtraction shall be termed the costs to be met by charge payers (i.e., self-pay, commercial insurers).

   c. Divide the costs to be met by charge payers by the projected charge pay mix of the hospital in the rate year. The results of this division shall be termed the maximum gross patient service revenue for the rate year.

   d. The Commission will then compare the hospital's maximum GPSR for the rate year to the amount of GPSR that the hospital has requested in its rate submission. The Commission shall determine the lower of a hospital's maximum GPSR or a hospital's requested GPSR as the

hospital's approved GPSR for the rate year.

2. Determination of GPSR for Hospitals without Proper Data on Charges

For those hospitals who lack appropriate data on base-year charges, as well as for any hospital that elects to use this method rather than the method described in **Section III.D.1 above, GPSR is calculated as follows:**

a. Calculate the ratio of base-year actual total RFR to the total base-year non-charge pay reimbursement. This ratio is called the Revenue Need Factor. The Revenue Need Factor shall not be less than one.

b. Multiply the hospital's rate year RFR by the Revenue Need Factor to obtain an approved rate-year gross patient service revenue.

3. Determination of GPSR for a New Service

GPSR for a new service is calculated according to the following formula:

New Service GPSR =

$$\left(\frac{\textbf{New Service RFR*}}{\textbf{Total RFR*}}\right)^{\text{X}} \text{(Total GPSR)}$$

* As described in Section III.D

III.E. New Hospital

For hospitals which were not licensed and/or operated as a non-acute hospital in FY 1993 or did not report a full year of actual costs in FY 1993, the base year for operating and capital costs shall be the year used in the hospital's first RFR calculation.

If the base year RFR was not based on a full year of actual costs, the

Commission shall determine whether to utilize the base year RFR information , establish a different base year in accordance with Medicare regulations at 42 CFR 413.40(f)(1)(i), or to evaluate the hospital's projected operating and capital costs for reasonableness. The criteria for such review will include, peer group analysis of costs incurred by comparable facilities.

For a new hospital where base year RFR information is not used , the Commission shall make any necessary adjustments according to the provisions of 114. CMR 40.07 and 114.1 CMR 40.08 (See Appendix I.).

III.F. Rates of Payment for Medicaid Services

1. Rates of Payment for Inpatient Services

Initial Medicaid rates of payment for all eligible hospital services are equal to the payment-on-account factor (PAF) multiplied by the approved charge for a service. Each PAF is hospital specific and is calculated as follows:

Rate-Year PAF =

(Rate-Year RFR)
(Rate-Year GPSR)

A supplementary payment is added to the initial rate of payment for all eligible services supplied by state-owned nonacute hospitals to publicly assisted patients requiring hospital level of care. The supplementary payment is equal to the following:

Total Supplementary Payment =

(Total Routine Charges for AD Patients x (PAF)) -
($111 x Number of Administrative Days)

No supplementary payment is given to a state-owned nonacute hospital where the product of its daily charge for

routine services supplied to an administrative day patient multiplied by the PAF calculated in accordance with this section is less than $111, the routine per-diem payment for an administrative day specified in Section III.F.2 below.

2. Rates of Payment for Administrative Days

a. For eligible routine services furnished to administrative day patients, the rate of payment will be the lesser of $111 per patient day or the PAF determined, times the hospital's approved routine charge.

b. For eligible ancillary services furnished to administrative day patients, the rate of payment shall be equal to the PAF determined times the approved charge for the service.

III.G. Payment Adjustment for Disproportionate Share Hospitals

General Provisions

None of the state-owned non-acute hospitals in the Commonwealth offer obstetric services. In accordance with Section 1923 of the Social Security Act (42 U.S.C. 1396r-4), the Commonwealth will make payment adjustments to state-owned nonacute hospitals which serve, a disproportionate number of low-income patients. Eligibility requirements and the methodology for calculating the adjustment are described below.

1. Determination of Eligibility

a. A state-owned non-acute hospital is eligible for a disproportionate-share adjustment if:

(i) the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or

the hospital's low-income utilization rate exceeds twenty-five (25) percent, and

(ii) its Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total patient days, is not less than one percent (1%).

b. Payment Adjustment Amount

The total of all disproportionate share payments awarded to a particular hospital under this section shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients

(i) The total amount of funds allocated for payment to non-acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement shall be $150,000 per year.

(ii) The total amount of funds to be allocated for each year will be distributed amongst the qualifying state-owned nonacute hospitals for that year, in accordance with the determination of eligibility described in Section III.G 1 (a)above. The distribution of these funds will be made according to the following methodology: For each hospital which qualifies under 1. a. i. above:

- the relative ratio of a hospital's Medicaid inpatient utilization rate to one standard deviation of the mean Medicaid inpatient rate for hospitals receiving Medicaid payments in the state will be calculated;

- o a state-owned nonacute hospital's relative ratio as determined above will be multiplied by a base amount in order to determine the payment adjustment amount for that state-owned nonacute hospital. The base amount shall be calculated such that the distribution of funds among qualifying hospitals under 1.a. and 1.b. above, shall equal the amount specified **in Section III.G .1.b.(i).**

Example: The mean Medicaid inpatient utilization rate in the state is 0.45 with a standard deviation (std) of .07. **No hospital shall be eligible unless the criteria set forth in section III.G.1.a above are met.**

(A) Qualifying Hospitals	(B) Medicaid Inp. Util. Rate	(C)** Ratio of Hosp. Med. Util. Rate to Mean plus std*	Payment Adjustment
A	0.55	1.0577	15,412.53
B	0.60	1.1538	16,812.87
C	0.69	1.3270	19,336.69
D	0.71	1.3654	19,896.25
		TOTAL:	$71,458.34

* Mean (0.45) + std (.07) = 0.52.

** Fiscal year 1992, 1993 and 1994 base amount equals $14,571.74.

- o for each hospital which qualifies under 1.a.ii. but not 1.a. i. above:

A base amount of the total allocated amount specified in a. above, plus an additional amount, calculated on the base and proportionate to the amount that such hospital's low income utilization rate exceeds twenty-five percent, shall be determined.

Example: Five hospitals' low-income utilization rates are at or above 25% and such hospitals do not qualify under 1.a.i. above.

One hospital's low income utilization rate is 25%, while the rest exceed the 25% rate.

(1) Qualifying Hospitals	(2) Low Income Util. Rate	(3) Ratio of Low Inc. Util.Rate	(4) Payment Adjustment*
A	.25	1.00	$14,571.74
B	.26	1.01	14,717.45
C	.31	1.06	15,446.04
D	.40	1.15	16,757.50
E	.42	1.17	17,048.93
			$78,546.66

* FY92 base amount equals $14,571.74

** Total for hospitals qualifying under either III.G.1.a.i. or 1.a.ii. equals $150,000 as specified in **III.G.1.b. (i)**

2. Pediatric Outlier: For Infants Under One Year of Age

a. In accordance with section 1902 of the act as amended by Section 4604 of OBRA 90, effective July 1, 1991, the Commonwealth will make an annual payment adjustment to **State-Owned Non-acute hospitals** for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay.

b. Determination of Eligibility. Determination of eligibility for infants under one year of age shall be made as follows:

1. Exceptionally long lengths of stay.

(a) First calculate the statewide weighted average Medicaid inpatient length-of-stay. This shall be determined by dividing the sum of Medicaid days for all State-Owned Non-acute hospitals in the state **by the sum of total discharge for all state-owned non-acute hospitals in the state.**

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient length-of-stay statistics.

(c) Third, add one and one-half times the state wide weighted standard deviation for Medicaid inpatient length-of-stay to the state wide weighted average Medicaid inpatient length-of-stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute and exceptionally long length-of-stay for purposes of payment adjustments under this section.

2. Exceptionally High Cost. For each **State-Owned non-acute hospital** providing services on or after July 1, 1991 to individuals under one year of age the Commonwealth shall:

(a) First, calculate the average cost per Medicaid inpatient discharge for each hospital;

(b) Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital;

(c) Third, add one and one-half times the hospital's standard deviation for the cost per Medicaid inpatient discharge to the hospital's average cost per Medicaid inpatient discharge. Any cost which equals or exceeds the sum of these two numbers shall constitute an exceptionally high cost for purposes of payment adjustments.

(i) The amount of funds allocated shall be twenty five thousand dollars ($ 25,000) for **FY 1997**. This includes Psychiatric, Chronic/Rehabilitation, and State-Owned Nonacute hospitals.

(ii) Any Hospital which qualifies for a payment adjustment for infants under one shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying **State-Owned Non-acute Hospitals** would exceed the total, each share shall be proportionately reduced to stay within the allocation.

3. Children Under Six

a. Eligibility for Payment. Consistent with section 4604 of the Omnibus Reconciliation Act of 1990 (OBRA 90) outlier adjustments for medically necessary inpatient hospital services , effective July 1, 1991, involving exceptionally high costs or exceptionally long lengths of stay **(as defined in Sections III. G. 2.b.2. of this Plan),** are extended to services for children who have not reached the age of six, if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923 (a) of the Social Security Act.

b. Amount of Payment Adjustment

(i) The amount of funds allocate shall be twenty five thousand dollars ($ 25,000) for FY **1997**. This includes Psychiatric, **Non-State-Owned** Chronic/Rehabilitation, and State-Owned Nonacute hospitals

(ii) Any Hospital which qualifies for a payment adjustment for children under six, pursuant to 2.A.) above shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying **State-Owned Non-acute** hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

4. Extraordinary Disproportionate Share Adjustment for Psychiatric Hospitals

In accordance with 1923 (C)(3) of the Social Security Act (42 U.S.C. 1936r-4), effective July 2, 1994, the state of Massachusetts shall provide an extraordinary disproportionate share adjustment for all eligible psychiatric hospitals. The following is a detailed description of the methodology to be used to determine the eligibility for the extraordinary disproportionate share adjustment.

a. Determination of Eligibility

A nonacute hospital is eligible for an extraordinary disproportionate share payment if the hospital is a nonacute psychiatric hospital that:

(i) specializes in providing psychiatric/psychological care and treatment;

(ii) provides for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;

(iii) accepts all patients without regard for the ability to pay;

(iv) consists partly or wholly of locked wards;

(v) meets requirements for the receipt of federal matching funds;

(vi) has a low-income utilization rate that exceeds 45%; and

(vii) has 50% or more of its costs that are not reimbursed.

b. Determination of Eligibility Under the Low-Income Utilization Method

(i) Data Source -- the FY 1994 RSC-403 report shall be

used to determine the cost, free care, charge, patient day, and net revenue amounts. The Commission may adjust a hospital's FY 1994 data if necessary to reflect major changes occurring between FY 1994 and the rate year. If said RSC-403 report is not available, the **Commission** shall use the most recent available previous RSC-403 report to estimate these variables. If the specified data source is unavailable, then the Commission shall determine and use the best alternative data source.

(ii) Low-Income Standard

a. For each nonacute psychiatric hospital, the **Commission** shall calculate the hospital-specific low-income utilization rate as follows:

- o divide each nonacute psychiatric hospital's net Medicaid revenue by its total gross patient service revenue; and
- o divide each nonacute psychiatric hospital's inpatient free care charges by its total charges.
- o The total of these percentages shall equal the nonacute psychiatric hospital's low-income utilization rate.

b. If the hospital-specific low-income utilization rate exceeds 45%, then the nonacute psychiatric hospital meets the low-income standard.

C. Unreimbursed Cost Standard

(i) For each nonacute psychiatric hospital, the **Commission** shall calculate the hospital-specific low-income utilization rate as follows:

- o calculate the costs of providing hospital services to eligible individuals and uninsured individuals by multiplying Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges.

- o Subtract the total of Medicaid payments (excluding any disproportionate share payment) plus self pay payments to determine the percentage of unreimbursed costs, and

- o divide the amount of unreimbursed costs by the costs of providing hospital services to eligible individuals and uninsured individuals to obtain the percentage of unreimbursed costs.

(ii) If the hospital-specific percentage of unreimbursed costs exceed 50%, then the nonacute psychiatric hospital meets the unreimbursed cost standard.

d. Determination of Payment Amount -- The payment under the extraordinary disproportionate share adjustment requirement shall be calculated as follows:

(i) First determine the estimated rate year cost of providing hospital services to Medicaid

eligible individuals and uninsured individuals **as set forth in C.(i) above,** substituting the rate year Medicaid RFR for FY1994 RFR.

(ii) Then, multiply this cost by the FY1994 unreimbursed cost percentage **determined pursuant to Section C.(i) above.**

(iii) Payments made pursuant to this action are subject to health Care Financing Administration approval of the state plan amendment incorporating this methodology.

5. Extraordinary Disproportionate Share Adjustment for State Owned Special Population Hospitals

Effective July 2, 1994, in accordance with 1923 (C)(3) of the Social Security Act (42 U.S.C. 1936 r-4) effective July 2, 1994, the Commonweath of Massachusetts shall provide an extraordinary disproportionate share adjustment for all eligible state-owned special population hospitals. The following describes the methodology to be used to determine the eligibility for the extraordinary disproportionate share adjustment:

a. Determination of Eligibility

A nonacute state-owned hospital is eligible for an extraordinary disproportionate share payment if the state-owned special population hospital:

(1) specializes in providing treatment to AIDS patients, tuberculosis patients, the medically needs homeless, multiply-handicapped pediatric patients and patients with combined medical and psychiatric needs;

(2) provides for special active treatment such as treatment of deafness, developmental disabilities,

and the elderly;

(3) accepts all patients without regard to their ability to pay;

(4) meets requirements for the receipt of federal matching funds;

(5) has a low-income utilization rate that exceeds 45%; and

(6) has costs 50% or more which are not reimbursed.

b. Determination of Eligibility Under the Low-Income Utilization Method

(1) Data Source - The FY 1994 RSC-403 report shall be used to determine the cost, free care, patient day, and net revenue amounts. The Commission may adjust a hospital's FY 1994 data if necessary to reflect major changes occurring between FY 1994 and the rate year. If said RSC-403 report is not available, the **Commission** shall use the most recent available previous RSC-403 report to estimate these variables. If the specified data source is unavailable, then the **Commission** shall determine and use the best alternative data source.

(2) Low-Income Standard

a. For each nonacute state-owned special population hospital, the **Commission** shall calculate the hospital-specific low-income utilization rate as follows:

o divide each hospital's net Medicaid revenue by its total gross patient

service revenue.

- o divide each hospital's free care charges by its total charges
- o the total of these percentages shall equal the hospital's low-income utilization rate.

b. If the hospital-specific low-income utilization rate exceeds 45%, then the state-owned special population hospital meets the low-income standard.

(3.) Unreimbursed Cost Standard

a. For each state-owned special population hospital, the **Commission** shall calculate the hospital-specific unreimbursed cost percentage as follows:

- o calculate the cost of providing hospital services to eligible individuals and uninsured individual by multiplying the Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges;
- o subtract the total of Medicaid payment (excluding any disproportionate share payment) plus self pay payments to determine the percentage of unreimbursed costs; and
- o divide the amount of unreimbursed costs by the costs of providing hospital services to eligible individuals

and unreimbursed individuals.

b. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the state-owned special population hospital meets the unreimbursed cost standard.

c. Determination of Payment Amount - the payment under the extraordinary disproportionate share adjustment for state owned special population hospitals requirement shall be calculated as follows:

- First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals **as set forth in Section III.G.5.b.(3.)a.,** substituting rate year Medicaid RFR for FY 1994 RFR.

- Then multiply the cost by FY1994 unreimbursed cost percentage **determined pursuant to Section III.G.5.b.(3.)a.**

- Payments made pursuant to this section are subject to Health Care Financing Administration approval of state plan amendment incorporating this method.

6. **Limits on Allocation of Funds. The total amount of funds allocated for payment to state owned non-acute hospitals may be proportionately reduced to stay within the federal DSH allotment limits for disproportionate share payments pursuant to 42 U.S.C. 1396r-4.**

III.H. Other Adjustment Processes

Hospital costs and charges may also be adjusted by the following processes:

1. Administrative Adjustment

(a) A hospital may at any time during a rate year apply for an administrative adjustment if there has been an arithmetic error in the calculation of the PAF. The Commission will not entertain an application an adjustment if the hospital is seeking to reverse a substantive determination pursuant to 114.1 CMR 40.00.

(b) A hospital may apply at any time during the first nine months of the rate year for an administrative adjustment based upon a request for a cost beyond control or a new service as described **in Sections III.B.3. and III.B.4.**

2. Administrative Review

a. Purpose of Administrative Review

To assure that a hospital's rates and new charges are in continuing compliance with this part, the Commonwealth, may at any time and upon its own motion, review the rates upon notice to the hospital.

b. Administrative Review of Transfers of Costs

Where a hospital has reduced or increased costs reported by transfer of those costs to or from other persons or entities which provide health care and services, the Commission may modify Reasonable Financial Requirement to reflect the change in cost. In order to give effect to a transfer of cost each hospital must file information concerning cost, volume, and revenue 30 days prior to implementation

of a proposed transfer of cost, and must submit any additional information regarding that transfer which the Commission may require.

3. Appeal

A state-owned nonacute hospital which is aggrieved by an action or failure to act under 114.1 CMR 40.00 may file an appeal within thirty (30) days to the Division of Administrative Law Appeals pursuant to the requirements of M.G.L. c. 6A, §42. The pendency of an appeal does not limit the Commission's rights to undertake administrative review of charges.

The Commonwealth's Budget Reform and Control Act of Chapter 653, Act of 989, Section 84

The Division shall review, and approve or disapprove, any change in rates or in rate methodology proposed by the Rate Setting Commission. The Division shall review such proposed rate changes for consistency with Department policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the Commission; provided, that the Division shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the House and Senate Committees on Ways and Means. The Division shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the Commission together with such recommendations for changes. Such disapproval and recommendations for changes, if any, shall be submitted to the Commission after the Division is notified that the Commission intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the Commission regarding such rate change; provided that no rates shall take effect without the approval of the Department. The Commission and the Division shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the House and Senate Committees on Ways and Means. The Commission shall supply the Department with all statistical information necessary to carry out the Department's review responsibilities under this Section. Notwithstanding the foregoing, said Department shall not review, approve, or disapprove any such rate set pursuant to Chapter Twenty-Three of the Acts of Nineteen Hundred and Eighty-Eight.

If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the Department to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the Department and the Commission shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Department under Title XIX of the Federal Social Security Act.